Certification of Practice Setting

Please list the actual street address of the practice setting where the applicant is working, or has entered into an agreement to provide services under this program during the next three (3) years. **The administrative officer must sign this certification.** The completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable.

Applicant's Name: _____

Practice Setting: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____

Start Date: _____/_____/_____ ☐ F/T or ☐ P/T % of hours to be provided at this site: _____

Through our selection process, I have determined that the applicant can speak the following Medi-Cal threshold language(s):

- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Cantonese
- ☐ Farsi
- ☐ Hmong
- ☐ Korean
- ☐ Mandarin
- ☐ Other Chinese
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese

I certify that the practice setting will pay the applicant prevailing wages and that I agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.).

I certify that this facility meets the definition of a "practice setting" as defined in California Health and Safety Code Section 1285522(f). This information will be verified with the Health Professions Education Foundation.

I declare under penalty of perjury that these statements are true and correct.

Name: (Please Print)_____

Signature: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____

Attach Business Card Here